DEPARTMENT OF DISABILITIES, AGING AND INDEPENDENT LIVING

Division of Licensing and Protection 103 South Main Street, Ladd Hall Waterbury, VT 05671-2306 http://www.dail.vermont.gov Voice/TTY (802) 871-3317 To Report Adult Abuse: (800) 564-1612 Fax (802) 871-3318

April 16, 2012

Ms. Theresa Southworth, Administrator Gill Odd Fellows Home 8 Gill Terrace Ludlow, VT 05149

Provider #: 475052

Dear Ms. Southworth:

Enclosed is a copy of your acceptable plans of correction for the survey conducted on **March 14, 2012.** Please post this document in a prominent place in your facility.

We may follow up to verify that substantial compliance has been achieved and maintained. If we find that your facility has failed to achieve or maintain substantial compliance, remedies may be imposed.

Sincerely,

Pamela M. Cota, RN, MS

mlaMCHaRN

Licensing Chief

PC:ne

Enclosure



SERVICES SERVICES

RECEIVED Division of PRINTED: 03/29/2012 FORM APPROVED

OMB NO: 0938-0391

	OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDING	Protection	(X8) DATE SURVEY
		475052	B. WING		03/14/2012
	PROVIDER OR SUPPLIER D FELLOWS HOME		8	EET ADDRESS, CITY, STATE, ZIP CODE GILL TERRACE JDLOW, VT 05149	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	JLD BE COMPLETION
F 000	INITIAL COMMEN	rs	F 000		
	conducted an unan	ensing and Protection nounced on-site annual		F-250 – Provision of Medio related Social Services.	ally
F 250 SS=D	The following deficing recertification surved 483.15(g)(1) PROVERLATED SOCIAL The facility must preservices to attain or services.	ISION OF MEDICALLY SERVICE ovide medically-related social remaintain the highest I, mental, and psychosocial	F 250	Late entry note written for resident #53 to reflect conversation with guardian dethe first week of admission, or discharge planning to reflect I placement. Call to guardian of March 16, 2012 and discharge confirmed.	f LTC n
	by: Based on record refacility failed to produces to attain or practicable physical well being of 1 of 2	NT is not met as evidenced eview and staff interview, the vide medically-related Social or maintain the highest II, mental and psychosocial Residents (Resident #53) ge 2 sample. The findings		All residents or their families contacted related to discharge care planned appropriately. A single social worker named ensure documentation. Care Plan meeting note works has been updated to include	to
	was admitted on 10 diagnosis including fracture related to a Services initial asse admitted for short to return home with a 1-2 months. Per result in the return home with a 1-2 months and 1-2/2/1 discharged from photo meeting all physical results.	w on 3/14/12, Resident #53 0/13/2011 with numerous failure to thrive and a bone a fall. Per review of the Social essment, Resident #53 was erm rehabilitation and was to nticipated length of stay to be view of the physical therapy 1, Resident #53 was nysical therapy services related ical therapy goals. Review of nowed no evidence of what		discharge planning and will be reviewed at every care plan meeting for every person. MDS coordinator or designee ensure compliance. This will be reviewed at the Quality Assure Meetings to ensure compliance. Substantial compliance obtain by April 13, 2012.	will pe ance ce.

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

If continuation sheet Page 1 of 17

(X6) DATE

TITLE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICARD SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1): PRÓVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			URVEY ETED
		475052	B. WIN	IG		03/1	4/2012
	PROVIDER OR SUPPLIER D FELLOWS HOME			8	EET ADDRESS, CITY, STATE, ZIP CODE GILL TERRACE UDLOW, VT 05149		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPE DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 250 F 282 SS=E	of Resident #53's of is no evidence that during the meetings. Review of the company 10/20/11, 10/30/11 was coded that Rewas that "return to feasible". Per reviecomprehensive car of any discharge placility Administrate Services (DNS) on confirmed that ther medical record of the disposition had been interdisciplinary tea and there was note Resident #53's dischanged from return community not feasible from the services provied was 20(k)(3)(ii) SEI PERSONS/PER Company 10 per	position was to be. Per review the plan meeting notes, there disposition was discussed in the presence of the plan the community was not the community was not the community was not the plan, there was no evidence anning. Per interview with the prand Director of Nursing 3/14/12 at 10:34 AM, it was the was no evidence within the prand that Resident #53's discharge that Resident #53's family evidence to explain why charge disposition had reported to the property of the plan that Resident #53's family evidence to explain why charge disposition had reported to the property of the plan that Resident #53's family evidence to explain why charge disposition had reported to the plan that Resident #53's family evidence to explain why charge disposition had reported to the plan that Resident #53's family evidence to explain why charge disposition had reported to the plan that Resident #53's family evidence to explain why charge disposition had reported to the plan that Resident #53's family evidence to explain why charge disposition had reported to the plan that Resident #53's family evidence to explain why charge disposition had reported to the plan that Resident #53's family evidence to explain why charge disposition had reported to the plan that Resident #53's family evidence to explain why charge disposition had reported to the plan that Resident #53's discharge that Resident #53's family evidence to explain why charge disposition had reported to the plan that Resident #53's discharge that		250	F282 – SERVICES BY QUALIFIED PERSONS/PER OPLAN Resident # 53 screened by Occupational therapy. Residents #20, # 5, # 2 and # 1 have call bell hooked to bed at hand bell attached to wheelch	C ARE 1 nd a	

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: CIL611

Facility ID: 475052

If continuation sheet Page 2 of 17

To Administrator 4-10-12

DEPARTMENT OF HEALTH AND HUMAN SERVICES

PRINTED: 03/29/2012 FORM APPROVED OMB NO. 0938-0394

STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER			PLE CONSTRUCTION	(X3) DATE SI COMPLE	JRVEY
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		475052	B. WI	VG		03/1	4/2012
NAME OF P	ROVIDER OR SUPPLIER			STR	EET ADDRESS, CITY, STATE, ZIP CODE		
GILL OD	D FELLOWS HOME			ı	GILL TERRACE		
				L	UDLOW, VT 05149		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
F 282	Continued From parinclude: 1. Per record review was admitted on 10 diagnosis including fracture related to a admitted for short to return home with an 1-2 months. Per reviterapy documental evaluated on 10/18 Occupational Thera weakness and mala indicated that Resident attreatment 5 days a (activities of daily like exercise, therapeut re-education. The continue of the part of the Occupational mobility, Per review of the part of the Occupational dated 11/23/11 the discontinue occup staffing issues." Per Therapy Discharged discharged from see documentation indicated record the Occupational Therapy Discharged from see documentation indicated record the Occupational Therapy Discharged from see documentation indicated record the Occupational Therapy Discharged from see documentation indicated record the Occupational Therapy Discharged from see documentation indicated record the Occupational Therapy Discharged from see documentation indicated record the Occupational Therapy Discharged from see documentation indicated record the Occupational Therapy Discharged from see documentation indicated record the Occupational Therapy Discharged from see documentation indicated record the Occupational Therapy Discharged from see documentation indicated the do			282		ab ntial use ed to ensure ts.	
	with the Director of	ter 11/23/11. Per interview Therapy Services on 3/14/12 e confirmed that a resident					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: CIL611 Facility ID: 475052

If continuation speet Page 3 of 17

PRINTED: 03/29/2012 CO DERARTMENT OF HEALTH AND HUMAN SERVICES

CENTE	RS FORMEDICARE	MEDIGAID SERVICES ****	· YOU		BY MINER L BROAFEFOME UP	OMB NO	C0938-0391
	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M		TIPLE CONSTRUCTION	(X3) DATE SURVEY	
		475052	B. WII	NG .		03/1	4/2012
NAME OF F	PROVIDER OR SUPPLIER			ST	TREET ADDRESS, CITY, STATE, ZIP CODE		
GILL OD	D FELLOWS HOME				8 GILL TERRACE LUDLOW, VT 05149		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRE- (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 282	can only be dischar they have met all the reached their maxing confirmed that disconfirmed to staffing is Director confirmed received any Occupations on 11/23/11 the Occupational Translated that Resignals and that the staffing indicated	rged from therapy services if here goals or if they have mum potential. The Director ontinuing therapy services is used is not appropriate. The that Resident #53 had not pational Therapy services after ontinued secondary to staffing. The Director confirmed that herapy discharge summary dent #53 had not met 2 of 4 is summary did not indicate it is a summary did	F	282	2		
	Resident #20 was in above the bed appropriate appropriate above the bed appropriate appropriate above the bed appropriate appr	on 3/12/12 at 2:28 PM, n bed with the call bell located roximately 3 feet out of the #20. Per observation on , Resident #20 was in bed with above the bed approximately ach of Resident #20. Per e was no evidence noted that any physical limitations from utilizing a call bell. Per ent #20's care plan titled, "At d to falls" dated 2/20/12, the each while resident is in the n also indicated that Resident n staff for activities of daily a recent falls. Per interview Nursing (DNS) on 3/13/12 at dicated that his/her					

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expectation of staff was that all call bells are to be within the residents reach when the resident is in

their room. The DNS visually and verbally confirmed that the call bell for Resident #20 was

Event ID: CIL611

Facility ID: 475052

If continuation sheet Page 4 of 17

DEPARTMENT OF HEALTH AND HUMAN SERVICES

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	- 1` '	IULTIP	LE CONSTRUCTION	(X3) DATE S COMPLE	
	·	475052	B. WII	NG		03/1	4/2012
	PROVIDER OR SUPPLIER D FELLOWS HOME			8 (EET ADDRESS, CITY, STATE, ZIP CODE GILL TERRACE JDLOW, VT 05149		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 282	3. Per observation Resident #5 was in wheelchair at the lebed. It was observed was on the overbed approximately 2 fer reach. Per record in noted that Resident limitations prevention bell. Per review of titled, "At risk for in 3/4/12, the call bell is in the room. The Resident #5 has in visually impaired. For Nursing (DNS) of indicated that his/h	bed approximately 3 feet, out sident #20. on 3/12/12 at 2:47 PM, his/her room sitting in a left side of the foot of his/her led that Resident #5's call bell did table at the foot of the bed let away from the resident's review, there was no evidence let #5 had any physical light may be a call the Resident #5's care plan lightly related to falls" dated list to be in reach while resident a care plan also indicated that in paired balance and gait and is the period of staff was that the be within the residents reach	F	282			
	Resident #2 was in wheelchair on the I bell was observed Resident #2's bed approximately 2 fer Per record review, that Resident #5 hapreventing him/her review of the Resident #5 for injury related bell is to be in reach The care plan also decreased balance	on 3/12/12 at 2:47 PM, in his/her room sitting in his/her left side of the bed. The call to be on the right side of attached to the side rail, et from Resident #2's reach, there was no evidence noted ad any physical limitations from utilizing a call bell. Per dent #5's care plan titled, "At ed to falls" dated 3/4/12, the call the while resident is in the room, indicated that Resident #2 had e, muscle wasting, and was atterview with the Director of					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: CIL611

Facility ID: 475052

If continuation sheet Page 5 of 17

	F OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLÍA IDENTIFICATION NUMBER;	(X2) MULTIF	PLE CONSTRUCTION (X3) DATE S COMPL	
		475052	B. WING	03/1	14/2012
	ROVIDER OR SUPPLIER D FELLOWS HOME		.8	EET ADDRESS, CITY, STATE, ZIP CODE GILL TERRACE UDLOW, VT 05149	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 282 F 311 SS=D	indicated that his/hall call bells are to when the resident 5. Per observation Resident #11 was call bell was obser #11's bed attached feet away from Rereview, there was review, there was review of the Resident #11 had preventing him/her review of the Resident sto be in room. The care pla #11 had history of Director of Nursing he/she indicated the was that all call be residents reach whom. The DNS vist that the call bell for Resident #11's bed approximately 2 fer reach. 483.25(a)(2) TREATIMPROVE/MAINTAL	3/13/12 at 2:20 PM, he/she her expectation of staff was that be within the residents reach is in their room. on 3/13/12 at 2:05 PM, in bed in his/her room and the ved to be above Resident it to the wall approximately 2 sident #11's reach. Per recording evidence noted that any physical limitations from utilizing a call bell. Per dent #11's care plan titled, "At ed to falls" dated 2/12/12, the reach while resident is in the an also indicated that Resident falls. Per interview with the g (DNS) on 3/13 at 2:20 PM, hat his/her expectation of staff lls are to be within the nen the resident is in their sually and verbally confirmed in Resident #11 was above di attached to the wall et away from Resident #11's ATMENT/SERVICES TO AIN ADLS the appropriate treatment and in or improve his or her abilities	F 282	F-311 – TREATMENT/ SERVICES TO IMPROVE/ MAINTAIN ADLS Resident #53 has been screened by Occupational Therapy and picked up for services. All residents screened by rehab director or designee for potential rehab services. All residents will have a rehab screen at least quarterly triggered by the MDS scheduling process. Rehab Director or designee will ensure compliance. This will be	
		NT is not met as evidenced		reviewed at the Quality Assurance Meetings to ensure compliance. Substantial compliance obtained	
		eview and staff interview the		by April 13, 2012.	

FORM CMS-2567(02-99) Previous Versions Obşolete

Event ID: CIL611

Facility ID: 475052

If continuation sheet Page 6 of 17

	T OF DEFICIENCIES (1)	(X1): PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDIN	PLE CONSTRUCTION G		BURVĖY (1911.) ETED 14
		475052	B. WING _		03/	14/2012
	PROVIDER OR SUPPLIER D FELLOWS HOME		8	REET ADDRESS, CITY, STATE, ZIP (GILL TERRACE UDLOW, VT 05149		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIVE CROSS-REFERENCED TO THE DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE
F 311	facility failed to prov services to maintain practicable well bei	rige 6 vide appropriate treatment and or improve the highest ng of 1 resident (Resident e survey sample. The findings	F 311	F311 POC accepted 4 TDoughertyRN/ DYNC	flizliz otarn	
	was admitted on 10 diagnosis including fracture related to a admitted for short to return home with an 1-2 months. Per retherapy documental evaluated on 10/18 Occupational Thera weakness and malindicated that Resident weakness of daily life exercise, therapeut re-education. The off Resident #53's specificational mobility, toileting. Per review dated 11/23/11 "disting the Occupational dated 11/23/11 the	w on 3/14/12, Resident #53 0/13/2011 with numerous failure to thrive and a bone a fall. Resident #53 was erm rehabilitation and was to inticipated length of stay to be view of the Occupational ition, Resident #53 was /11 and was to receive apy for a diagnosis of general aise. The documentation dent #53 was to receive week for 5 weeks for ADL ving) training, therapeutic tic activities and neurological documentation indicated that recific goals were for grooming, dressing and bathing and v of the physician's orders scontinue skilled occupational to staffing issues." Per review I Therapy weekly summary plan was documented to ational therapy secondary to				
	Discharge Summa discharged from se documentation indinot met two of the	ry, Resident #53 was ry, Resident #53 was rvices on 11/23/11, and the cated that Resident #53 had four goals, the goal of nd toileting. Per review of the				

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: CIL611

Facility ID: 475052

If continuation sheet Page 7 of 17

A DEPARTMENT OF HEALTH AND HUMAN SERVICES A CONTROL OF MEDICARE & MEDICALD SERVICES

PRINTED: 03/29/2012

-1000-8860 10N BMO: 15

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A BUILDING B. WING 475052 03/14/2012 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **8 GILL TERRACE** GILL ODD FELLOWS HOME **LUDLOW, VT 05149** SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID ID (X5) COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL PRFFIX **PREFIX** (EACH CORRECTIVE ACTION SHOULD BE DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) F 311 Continued From page 7 F 311 medical record there was no evidence that Occupational Therapy Services were re-initiated for Resident #53 after 11/23/11. Per interview with the Director of Therapy Services on 3/14/12 at 10:13 AM, he/she confirmed that a resident can only be discharged from therapy services if they have met all there goals or if they have reached their maximum potential. The Director confirmed that discontinuing therapy services related to staffing issues is not appropriate. The Director confirmed that Resident #53 had not received any Occupational Therapy services after services were discontinued secondary to staffing issues on 11/23/11. The Director confirmed that the Occupational Therapy discharge summary indicated that Resident #53 had not met 2 of 4 goals and that the summary did not indicate whether Resident #53 had reached maximum potential for these goals. 483.25(h) FREE OF ACCIDENT F 323 F 323 HAZARDS/SUPERVISION/DEVICES SS=E F-323 - FREE OF ACCIDENTS The facility must ensure that the resident HAZZARDS/ SUPERVISION/ environment remains as free of accident hazards **DEVICES** as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. Residents #20, #5, #2 and #11 have call bell hooked to bed and a hand bell attached to wheelchair. Resident #7 and #2 have This REQUIREMENT is not met as evidenced wheelchair rests on wheelchair. Based on observation, record review and staff interview the facility failed to ensure that each resident receives adequate supervision and assistance devices to prevent accidents for 5 of 32 residents (Residents #20, 5, 2, 11 and 7)

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Event ID: CIL611

Facility ID: 475052

If continuation sheet Page 8 of 17

PRINTED: 03/29/2012 FORM APPROVED OMB NO: 0938-0394 -CENTERS FOR MEDICARE & MEDICAID SERVICES

AND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER	A. BUI		IG (X3)	COMPLET	
		475052	B. WIN	NG _		03/14	/2012
	PROVIDER OR SUPPLIER D FELLOWS HOME			8	REET ADDRESS, CITY, STATE, ZIP CODE B GILL TERRACE LUDLOW, VT 05149		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 323	identified during Strecertification survers. 1. Per observation Resident #20 was in above the bed appreach of Resident #3/13/12 at 1:15 PM with the call bell local approximately 3 fer Resident #20. Per evidence noted that physical limitations utilizing a call bell. #20's care plan title falls" dated 2/20/12 while resident is in indicated that Resident activities of daily falls Per interview (DNS) on 3/13 at 2 his/her expectation are to be within the resident is in their resident is in t	age 1 and Stage 2 of the ey. The findings include: on 3/12/12 at 2:28 PM, n bed with the call bell located roximately 3 feet out of the #20. Per observation on , Resident #20 was in bed cated above the bed et , out of the reach of record review, there was no it Resident #20 had any preventing him/her from Per review of the Resident ed, "At risk for injury related to 2, the call bell is to be in reach the room. The care plan also dent # 20 is dependant on staff y living, weakness and recent with the Director of Nursing 120 PM, he/she indicated that of staff was that all call bells is residents reach when the room. The DNS visually and that the call bell for Resident pove the bed approximately 3 ch of Resident #20. on 3/12 at 2:47 PM Resident pom sitting in a wheelchair at foot of his/her bed. It was dent #5's call bell was on the	F	323	All residents screened by Rehab Director or designee for the ability to use call bell and for use of foot rests on wheel chairs. Wheelchairs have been marked with the matching footrests. Staff has been educated about call bells and safe transportation of residents. Rehab screen forms are available on each nursing unit and staff has been educated about requesting a rehab screen. Care plans have been updated to reflect use of foot rests with transportation of residents. At minimum daily rounds to ensure call bells in reach and appropriate use of wheelchair footrests during transportation. Nurses and LNA's will be utilized in peer assessment of call bells and wheelchair footrest audits to enhance awareness and compliance. DNS or designee will ensure compliance. This will be reviewed at the Quality Assurance Meetings to ensure compliance. Substantial compliance obtained by April 13, 2012.	e	

FORM CMS-2567(02-99) Previous Versions Obsolet

Event ID: CIL611 Facility ID: 475052 If c

If continuation sheet Page 9 of 17

PRINTED: .03/29/2012 FORM APPROVED CENTERS FORMEDICARE & MEDICAID SERVICES OMB NOT0838-0391

STATEMENT OF DEFICIENCIES (27) PROVIDER/SUPPLIER/CLIA-AND PLAN OF CORRECTION (27) IDENTIFICATION NUMBER:		(X1), PROVIDER/SUPPLIER/CLIA- IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVÊY COMPLÊTED		
		475052	B. WIN	G		03/1	4/2012	
	PROVIDER OR SUPPLIER DD FELLOWS HOME		1	8 (EET ADDRESS, CITY, STATE, ZIP CODE GILL TERRACE JDLOW, VT 05149			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	OULD BE	(X5) COMPLETION DATE	
F 323	titled, "At risk for in 3/4/12, the call bell is in the room. The Resident #5 has im visually impaired. For Nursing (DNS) of indicated that his/hall call bells are to have the resident in the second review, that Resident #2 was in wheelchair on the bell was observed Resident #2's bed approximately 2 fee Per record review, that Resident #2 hapreventing him/her review of the Resident #10 hall call bell sare to law the resident in the resident in the resident in the resident #11 was in call bell was observenting him/her resident #11 was in call bell was observenting him/her resident #11 had a second him the resident	ury related to falls" dated is to be in reach while resident care plan also indicated that paired balance and gait and is er interview with the Director n 3/13 at 2:20 PM, he/she er expectation of staff was that be within the residents reach in their room. on 3/12/12 at 2:47 PM, his/her room sitting in his/her eff side of the bed. The call to be on the right side of attached to the side rail, et from Resident #2's reach, there was no evidence noted ad any physical limitations from utilizing a call bell. Per ent #2's care plan titled, "At d to falls" dated 3/4/12, the call h while resident is in the room, indicated that Resident #2 had, muscle wasting, and was terview with the Director of 3/13 at 2:20 PM, he/she er expectation of staff was that be within the residents reach	F3	123	F323 POC accepted 4/12 Thougherty RN/ Amoutan			

FORM CMS-2567(02-99), Previous Versions Obsolete

Event ID: CIL611

Facility ID: 475052

If continuation sheet Page 10 of 17

	FOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		ULTIPL LDING	E CONSTRUCTION : "		(X3) DATE S COMPLE	
		475052	B. WIN	IG			03/1	4/2012
	ROVIDER OR SUPPLIER D FELLOWS HOME			8 G	ET ADDRESS, CITY, STATE, ZIP ILL TERRACE DLOW, VT 05149	CODE		
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F 323	risk for injury relative call bell is to be in room. The care plus 11 had history of Director of Nursin he/she indicated the was that all call be residents reach work to DNS vor that the call bell for Resident #11's be	dent #11's care plan titled, "At ed to falls" dated 2/12/12, the reach while resident is in the an also indicated that Resident f falls. Per interview with the g (DNS) on 3/13 at 2:20 PM, hat his/her expectation of staff ells are to be within the hen the resident is in their isually and verbally confirmed or Resident #11 was above at attached to the wall eet away from Resident #11's	Fí	323				
· .	Resident # 7 was the dining room to observed that Reson the ground as wheelchair forwar Resident #7 had resident #7 was wheelchair down were dragging on was being pushed that Resident #7 to lift not able to and acharder onto the flower observation of # 7 was being trail	n 3/14/12 at 8:27 AM, Resident asported via wheelchair to the						
	had no foot rests	s observed that Resident #7 attached to the wheelchair. It en staff instructed to lift his/her						

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: CIL611

Facility ID: 475052

If continuation sheet Page 11 of 17

PRINTED: 03/29/2012 FORM APPROVED OMB NO: 0938-0391 CENTERS FOR MEDICARE & MEDICAID SERVICES

AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BÜI		NG	COMPLE	
		475052	B. WII	NG_	· · · · · · · · · · · · · · · · · · ·	03/1	4/2012
	ROVIDER OR SUPPLIER D FELLOWS HOME		- 1	1	REET ADDRESS, CITY, STATE, ZIP CODE 8 GILL TERRACE LUDLOW, VT 05149	1 00/1	4/2012
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 323	feet the resident was pushed his/her feet interview with the D he/she confirmed the transport of Resider observed that Reside on the floor as the swheelchair forward, there were no leg restract transporting and dragging on the floot the residents feet. Per review of Resider Assessments, there Resident #7 was even wheelchair for transmutilization of foot resper interview on 3/1 Physical Therapist (Resident #7 was not utilization of a wheel not made aware that his/her feet during that Resident #7's lebecome injured during the desident #2 was beto the dining room. If the dining room in the dining room in the dining room of the dining room in the dining room in the dining room in the dining room in the wheelch observed that staff in his/her feet during the was unable to compare the side of the dining the was unable to compare the side of the dining the was unable to compare the side of the dining the was unable to compare the side of the side	harder onto the floor. Per NS on 3/14/12 at 8:42 AM hat he/she had visualized the nt #7 by staff and had dent #7's feet were dragging staff member pushed the The DNS also confirmed that ests on the wheelchair and resident whose feet are or was a potential for injury to ent #7's Physical Therapy was no evidence that raluated for the utilization of a sport or evaluated for the sts for safety during transport. 412 at 8:42 AM with the PT), he/she indicated that of formally evaluated for the dichair for transport and was at Resident #7 was dragging ransport. The PT confirmed egs do not bend and could	F				

FORM CMS-2567(02-99) Previous Versions Obsolete

Event.ID: CIL611

Facility ID: 475052

If continuation sheet Page 12 of 17

PRINTED: 03/29/2012
PRINTED: 03/29/2012
FORM APPROVED

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION

		IDENTIFICATION NUMBER:		LDING	E CONSTRUCTION	COMPLE	
		475052	B. WII	1G		03/1	4/2012
NAME OF PROVIDER OR SUPPLIER GILL ODD FELLOWS HOME SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) F 323 Continued From page 12 Assessments, there was no evidence that Resident #2 was evaluated for the utilization of a wheelchair for transport or evaluated for the utilization of foot rests for safety during transport. Per interview on 3/14/12 at 8:42 AM with the Physical Therapist (PT), he/she indicated that Resident #2 was not formally evaluated for the utilization of a wheel chair for transport and was not made aware that Resident #2 was dragging his/her feet during transport. F 371		8 G	ET ADDRESS, CITY, STATE, ZIP CODE IILL TERRACE DLOW, VT 05149				
PREFIX	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 371	Assessments, there Resident #2 was ever wheelchair for transutilization of foot reper interview on 3/ Physical Therapist Resident #2 was not utilization of a wheel not made aware the his/her feet during 483.35(i) FOOD PFSTORE/PREPARETORE/PREPARETORE/PREPARETORE/PREPARETORE (1) Procure food from the considered satisfact authorities; and (2) Store, prepare,	e was no evidence that valuated for the utilization of a sport or evaluated for the sts for safety during transport. 14/12 at 8:42 AM with the (PT), he/she indicated that of formally evaluated for the el chair for transport and was at Resident #2 was dragging transport. ROCURE, //SERVE - SANITARY		323	F=371 — FOOD PROCURE, STORE/ PREPARE/ SERVE/ SANITARY Microwave was cleaned and i checked daily at the beginning each cooks shift.	s	
	by: Based on observation facility failed to storunder sanitary conductor at 10:26 AM, the resident food had conside roof of the mouth the Dietary Macleaned at the end confirmed that the				All unlabeled food products we discarded. Dietary Manager and Dietary Staff in-serviced related food safety. The intake vent was cleaned 3/13/2012 by Maintenance Director. Maintenance/dietar staff was educated on Infection Control Prevention related to storage and monthly cleaning schedule. DM to review and eduily, weekly and monthly cleaschedule followed.	nd ed to y on food	

FORM CMS-2567(02-99) Previous Versions Obsolete

If continuation sheet Page 13 of 17

Event ID: CIL611 Facility ID: 475052

Administrator

3 - DEPARTMENT OF HEALTH AND HUMAN SERVICES TO A SHOULD BE SEED OF THE SERVICES OF THE SERVICE PRINTED:, 03/29/2012 FORM APPROVED CENTERS EOR MEDICARE & MEDICAID SERVICES 於極端學 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X1) IDENTIFICATION NUMBER: (X1) (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION COMPLETED 4-A. BUILDING B. WING 475052 03/14/2012 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **8 GILL TERRACE** GILL ODD FELLOWS HOME **LUDLOW, VT 05149** SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION ID (X5)PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PREFIX** (EACH CORRECTIVE ACTION SHOULD BE COMPLETION REGULATORY OR LSC IDENTIFYING INFORMATION) TAG **TAG** CROSS-REFERENCED TO THE APPROPRIATE DATE DEFICIENCY) Popcorn popper has been cleaned F 371 Continued From page 13 F 371 and returned to service after cleaned after it was used last. obtaining food safe chemical for 2. Per observation on 3/12/12 at 10:35 AM, in the cleaning per manufacturers drink cooler there were two 8 ounce glasses guidelines. The activity staff has containing cranberry juice and milk. The glasses been educated on infection control were covered with lids but the lids were not and cleaning procedure. labeled with the date the drinks were placed into the cooler. In the main cooler it was observed at 10:39 AM that there were 6 gallon containers (1/2 LNA counseled related to hand gallon mustard, 1/2 gallon of ranch dressing, 3/4 washing and Infection Prevention gallon of dill pickles, 3/4 gallon of mayonnaise, in the dining room. and a 3/4 gallon container of green olives), not dated for when they were open. Per interview with Dining practices will be monitored the DM at 10:40 AM he/she confirmed that the for infection control a minimum of expectation is that staff label items when they are opened and placed in the cooler. The DM also 7 meals per week for food safety. confirmed that the facility had no policy regarding the labeling and storage of food products in the Dietary Manager or designee will coolers and that without the dates, the staff would monitor equipment in kitchen daily not be able to identify when the food items would for cleanliness of vent and notify no longer be safe to consume. maintenance if cleaning needed 3. Per observation on 3/12/12 at 10:40 AM in the before scheduled cleaning date. kitchen, it was observed that the intake vent Dietary manager or designee will located directly over the steam table and food monitor microwave for cleanliness preparation area was covered with thick black, twice daily. greasy appearing dust particles. Per interview with the DM, he/she indicated that the vents were

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maintained by the maintenance department. Per interview with the maintenance helper on 3/12/12

at 10:45 AM, he/she confirmed that the vent was

Per interview with the Maintenance Director (MD)

on 3/12/12 at 10:45 AM, he/she indicated that the vents are to be cleaned on a monthly basis. Per

documentation the last time the vent was cleaned

was 2/10/12. The MD indicated in interview that

coated with thick black, greasy dust particles.

review of the preventative maintenance

Event ID: CIL611

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Facility ID: 475052

If continuation sheet Page 14 of 17

4-10-12

Refrigerators will be checked daily

by dietary staff for labels on all

food with an open date. All staff

educated about infection control,

Blood borne pathogens (BBP) and

washing/sanitizing and dietary

the importance of hand

staff r/t food safety.

PRINTED: 03/29/2012 TEDERARIMENT OF FEALTH AND HUMAN SERVICES. FORM APPROVED CENTERS FOR MEDICAREIS MEDICAID SERVICES OMB NO 9938 938 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER COMPLETED '----A. BUILDING B. WING 475052 03/14/2012 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **8 GILL TERRACE** GILL ODD FELLOWS HOME **LUDLOW, VT 05149** SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID ID (X5) COMPLETION PRÉFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PREFIX DATE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG DEFICIENCY) Continued From page 14 F 371 Dietary Manager or designee will the facility did not have a policy or procedure for ensure compliance. This will be the cleaning of the vent system in the facility. reviewed at the Quality Assurance 4. Per observation on 3/12/12 at 10:47 AM, in the Meetings to ensure compliance. main dining room it was observed that the free standing popcorn popper contained popcorn Substantial compliance obtained particles in the main chamber and that the inside by April 13, 2012. of the glass windows were coated with a thick greasy film. Per interview with the DM, he/she indicated that the activities department was F371 POC accepted 4/12/12 responsible for maintaining the popcorn popper. TDougherty RN/ PMCotaRN Per interview on 3/12/12 at 10:47 AM with the temporary dietary/activity aide, he/she indicated that the popcorn popper was used for facility

observed wiping his/her nose with his/her bare hand and then did not sanitize or wash his/her hands before picking up the residents sandwich with the same hand and feeding the sandwich to the resident. Per interview the LNA he/she confirmed that he/she should have washed or sanitized his/her hands before feeding the resident after touching his/her nose.

F 441
SS=D SPREAD, LINENS

The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and

movie nights usually every two weeks. The aide

approximately a week ago and he/she confirmed that the popcorn popper had not been cleaned

5. On 3/12/12 at 12:07 PM during the lunch meal observation in the main dining room it was observed that a Licensed Nursing Assistant (LNA) was feeding a resident. The aide was

indicated that the last movie night was

F 441

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since its last use.

Event ID: CIL611

Facility ID: 475052

If continuation sheet Page 15 of 17

PRINTED: 03/29/2012 FDERARTMENT OF HEALTH AND HUMAN SERVICES: 选输 CENTERS FOR MEDICARES MEDICAID SERVICES € A. Ø MB NO 0938-039 STATEMENT OF DEFICIENCIES (X1)**PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING B. WING 475052 03/14/2012 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **8 GILL TERRACE** GILL ODD FELLOWS HOME **LUDLOW, VT 05149** SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID ID (X5) COMPLETION PRÉFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PREFIX** (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) DATE TAG TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) F 441 F-441 - INFECTION CONTROL, Continued From page 15 F 441 to help prevent the development and transmission PREVENT SPREAD, LINENS of disease and infection. The Medication Nurse has been (a) Infection Control Program counseled on blood-borne The facility must establish an Infection Control pathogens and infection control Program under which it -(1) Investigates, controls, and prevents infections practices. in the facility: (2) Decides what procedures, such as isolation, The LNA has been counseled should be applied to an individual resident; and regarding hand washing and (3) Maintains a record of incidents and corrective infection prevention. actions related to infections. Dining practices will be monitored (b) Preventing Spread of Infection for a minimum of seven meals per (1) When the Infection Control Program determines that a resident needs isolation to week for Infection control. prevent the spread of infection, the facility must isolate the resident. Staff educated on preventing (2) The facility must prohibit employees with a spread of Infection related to communicable disease or infected skin lesions dining and blood borne pathogens. from direct contact with residents or their food, if direct contact will transmit the disease. Hand sanitizers available on all (3) The facility must require staff to wash their tables in the dining room. hands after each direct resident contact for which hand washing is indicated by accepted Nurses, LNA's and Dietary staff professional practice. participate in the monitoring of Infection control in the dining (c) Linens

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infection.

by:

Personnel must handle, store, process and

transport linens so as to prevent the spread of

This REQUIREMENT is not met as evidenced

Based on observation and staff interview on 3/12/12, the facility failed to provide a safe and

Event ID: CIL611

by April 13, 2012. Facility ID: 475052

compliance.

It continuation sheet Page 16 of 17

room to enhance peer awareness.

Director of Nursing Services or designee will ensure compliance. This will be reviewed at the Quality Assurance Meetings to ensure

Substantial compliance obtained

DEPARTMENT OF HEACTH AND HUMAN SERVICES PARTMENT OF HEACTH AND HUMAN S

AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING (X3) DATE SURVEY COMPLETED				
		475052	B. WING		03/14/2012	
NAME OF PROVIDER OR SUPPLIER GILL ODD FELLOWS HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 8 GILL TERRACE LUDLOW, VT 05149			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		OULD BE COMPLÉTION	2
F 441		nt to help prevent the ransmission of disease and	F 44 1	F441 PDC accepted 411 TDoughesty RNI PM cotar	2/12 UN	
	main dining room d medication nurse w fingerstick (obtaining resident for the pur blood sugar level) f dining room table w eating. Per interview he/she confirmed the	on 3/12/12 at 12:16 PM in the uring the lunch service, the vas observed obtaining a ag a blood sample from a pose of testing the residents from a resident sitting at the vhile other residents were w with the medication nurse, nat the resident should have a the dining area when stick.				
	observation in the robserved that a Lic (LNA) was feeding observed wiping his hand and then did hands before pickir with the same hand the resident. Per in confirmed that he/s	207 PM during the lunch meal main dining room it was ensed Nursing Assistant a resident. The aide was sher nose with his/her bare not sanitize or wash his/her ng up the residents sandwich d and feeding the sandwich to terview the LNA he/she should have washed or ands before feeding the sing his/her nose.				

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: CIL611

If continuation sheet Page 17 of 17

Facility ID: 475052 Administration

CENTERS-FOR MEDICARE & MEDICARD SERVICES STATEMENT OF ISOLATED DEFICIENCIES WHICH CAUSE PROVIDER #.. MULTIPLE CONSTRUCTION DATE SURVEY NO HARM WITH ONLY A POTENTIAL FOR MINIMAL HARM A. BUILDING COMPLETE: FOR SNFs AND NFs 475052 B. WING 3/14/2012 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **8 GILL TERRACE** GILL ODD FELLOWS HOME LUDLOW, VT ID PREFIX SUMMARY STATEMENT OF DEFICIENCIES TAG F 278 483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED The assessment must accurately reflect the resident's status. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. A registered nurse must sign and certify that the assessment is completed. Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than \$1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than \$5,000 for each assessment. Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is not met as evidenced by: Based on interview and medical record review, the facility failed to accurately code the Minimum Data Set (MDS) for 2 residents (Residents #2 and #53) of the sample group with regard to impairment of legs. Findings include: 1. Per medical record review for Resident #2 on 03/14/2012 at 9:30 am, the coding of a '2' for leg impairment on both sides on the annual MDS dated 02/23/2012 indicates a decline from the coding on the previous 2 quarterly reviews done on 12/04/2011 and 09/11/2011. Resident #2 was coded on those 2 MDS assessments as '0' or no impairment in both legs. Per review of the nurses' notes and physical therapy notes, there has been no decline in the functional status of this resident during these assessment periods. The fact that the resident had no change in the function of her/his legs since admission is confirmed during interview with DNS on 03/14/2012 at 3:14 PM, as well as by interview with the primary physician on 03/14/2012 at 3:00 PM. The DNS further states that this is a coding error. 2. Per record review on 3/14/12, Resident #53 was admitted on 10/13/2011 with numerous diagnoses including failure to thrive and a bone fracture related to a fall. Per review of the Social Services initial assessment dated 10/16/11, Resident #53 was admitted for short term rehabilitation and was to return home

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of

with anticipated length of stay to be 1-2 months. Review of the MDS's dated 10/20/11 and 10/30/11 record Resident #53's discharge plan coded "return to the community was not feasible". Per review of the physical

The above isolated deficiencies pose no actual harm to the residents

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DEPARTMENT OF	HEALTH AND	HUMAN SERV	KES
CENTERS-FOR ME	DICAREM ME	DICAID:SERVIO	FS

	OF ISOLATED DEFICIENCIES WHICH CAUSE TH ONLY A POTENTIAL FOR MINIMAL HARM D NFs	PROVIDER # 475052	MULTIPLE CONSTRUCTION A', BUILDING B' WING	DATE SURVEY COMPLETE: 3/14/2012					
NAME OF PROVIDER OR SUPPLIER GILL ODD FELLOWS HOME		STREET ADDRESS, CITY, STATE, ZIP CODE 8 GILL TERRACE LUDLOW, VT							
ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENC								
F 278	Continued From Page 1 therapy notes dated 12/2/11, Resident #53 was discharged from physical therapy services having met all physical therapy goals. Per interview with the Director of Nursing Services on 3/14/12, he/she confirmed that the MDS dated 10/20/11 and 10/30/11 did not accurately reflect the assessment of Resident #53's "returning home" documented in the Social Service notes dated 10/16/11, and demonstrated by Resident #53 meeting all physical therapy goals.								

031099

Theresa Southwoods Aprinistratos 4-10-12 If continuation sheet 2 of 2